Wisconsin Shares Program Integrity Summary

Wisconsin Shares program assists low income families by providing subsidized child care. The budget for SFY11 was $341M. The number of children served during 2010 ranged from a high of 57,448 in July to 52,853 in December. The program is administered by the counties and tribes based on annual contracts with the department.

Child Care Subsidy Fraud Prevention:

- Program eligibility is processed thru the CARES system and involves multiple data matches.
- DCF provides counties and tribes with training, technical assistance, and, through the annual contracts, funding to assist with the investigation of fraud.
- Beginning in 2010, DCF required counties and tribes to submit an annual fraud plan outlining prevention, detection, and overpayment recovery efforts.
- In July 2010, DCF established a child care authorization unit in Milwaukee County with staff trained to identify common fraud indicators.
- In 2009, DCF provided regional licensing offices and MECA certifiers with common fraud indicators to identify during the child care licensing/certification process.
- In 2010, DCF created a Quality Improvement Unit in the Southeastern regional licensing office to enhance monitoring of licensed child care providers who have repeated licensing violations or child care subsidy violations.
- In 2009, state law changed to limit the number of employee children in a child care center to no more that 40%. DCF monitors compliance.
- In 2010, DCF developed additional attendance reporting modes that capture more detail about the actual time children attend child care.
- DCF developed a detailed training guide for statewide use with compliance training.

Child Care Subsidy Fraud Detection:

- Since 2009, DCF has suspended payments to more than 230 providers and established overpayments against clients and providers totaling $5.2M in 2009 and $9.2M in 2010.
- Since September 2009, DCF has received over 3,000 fraud referrals.
- DCF uses data mining to evaluate more than a dozen indicators associated with fraud.
- DCF tracks the movement of children who were displaced from closed providers.
- DCF expanded MECA Program Integrity efforts, hiring over 20 temporary staff.
- DCF is expanding 2nd and 3rd shift monitoring visits to ensure billed care is being provided.
- DCF has created child care anti-fraud task forces in Milwaukee, Racine, and Kenosha Counties to investigate child care providers whose fraudulent actions rise to the level of criminal violations. Milwaukee County has criminally charged 14 child care providers.
- MECA Client Investigations Unit has a fraud hotline and introduced a fraud email address.
- MECA Client Investigations Unit has cleared all the 2008-2009 acquired child care case backlog and investigated approximately 1,038 referrals.
- MECA has partnered with UWM to cross-match data from multiple agencies to ID fraud.

Child Care Subsidy Overpayment Recovery:

- DCF has established $14.4 M in overpayments against clients and providers since 2009.
- MECA established $3.7 M in client overpayments in 2010, and $1.7M in 2009.
- Overpayments against providers active in the subsidy program are offset against future issuances
- For providers no longer active in the subsidy program, DCF uses all tools available to the state to collect debt including: tax intercepts, levies, liens, and warrants. Since September 2009, $2.4 million has been forwarded to the PACU for formal collections.

W-2 Program Integrity Summary

The Department of Children and Families (DCF) contracts with 45 agencies for $245,177,450 (allocation period January 1, 2010 – December 31, 2011). The caseload in February 2011 was 17,436.

W-2 Fraud Prevention:

The Department of Children and Families (DCF) determines fraud policy based on federal regulations and state statute. The policies are communicated in the W-2 Manual and the Income Maintenance Manual. DCF contracts with W-2 agencies to administer the W-2 program according to policy. W-2 agencies are required to complete fraud plans which identify methods of fraud prevention. Front End Verification is one way to prevent fraud. W-2 applications with questionable information are referred to a specialist or investigator within the W-2 agency who will do a more in-depth verification of information provided for the application than the regular verification process. The regular verification process requires verification of identity, age, Wisconsin residence, citizenship/alien status, SSN, marital status, custody of children, household composition, income sources/amounts, and asset sources/amounts. Applications are completed in the CARES system. CARES has data exchanges with:

- Vital Records to verify date of birth for individuals born in Wisconsin and citizenship;
- Social Security Administration to verify SSN, SSI receipt, and SSI benefits amounts;
- U.S. Citizen and Immigration Services to verify alien status, and with
- Department of Workforce Development Unemployment Insurance to identify receipt of unemployment benefits, new hire data, and quarterly earnings.

W-2 Fraud Detection:

As indicated above, DCF determines fraud policy and contracts with W-2 agencies to administer the W-2 program. W-2 agencies are required to have a fraud plan which describes how they will detect fraud, and a Quality Assurance (QA) plan to ensure that W-2 policies and processes are being followed. Large agencies have QA units. Sources of fraud detection include:

- information regarding unreported income from data exchanges described in the paragraph above;
- expenses that exceed income;
- frequent moving;
- information provided by the participant that is contradictory, incomplete, or unclear;
- participant has made statements that are inconsistent with other information available;
- collateral contact statement is inconsistent with participant's statement of household size and composition;
- prior fraud with questionable data; and
- information from the general public of suspected fraud.

W-2 Overpayment Recovery:

DCF determines overpayment policy and process and supports the CARES system that automates the recovery process. When the W-2 agency identifies an overpayment, they calculate the amount of the overpayment, the time period, and the reason for the overpayment. The W-2 agency enters this information into CARES. If the participant is still receiving W-2 benefits, overpayments are recouped by withholding a portion of the W-2 benefit each month until the overpayment is recovered. If the individual is not receiving W-2 benefits, the W-2 agency attempts to enter into a voluntary repayment agreement with the participant agreeing to pay a specific amount each month. Overpayment notices and repayment agreements are sent from CARES. If the participant does not enter into a voluntary repayment agreement or does not make the repayments, the overpayment is referred to DCF's Public Assistance Collection Unit (PACU). PACU will attempt to recover the overpayment through lien, levy, and tax intercept.

Eligibility Process for Wisconsin Shares and Wisconsin Works

Overview for Wisconsin Shares (CC) and Wisconsin Works (W-2):

- Eligibility policy is based on federal regulations, and refined by state statutes and admin rule.
- Funding for CC and W-2 is primarily federal with some GPR and local support.
- The CC and W-2 programs contract with local agencies to determine eligibility and manage cases. CC eligibility is contracted to county human service agencies. W-2 agencies are a mix of county human services agencies and private agencies.
- Policies and procedures are communicated to local agencies through Operations Memos, the CC Manual and the W-2 Policy Manual.
- Wisconsin has adopted an automated system to manage all eligibility functions. The Client Assistance for Reemployment and Economic Support (CARES) Worker Web (CWW) system is a statewide, automated, integrated system that supports the programs of W-2, CC, Food Share (FS), and BadgerCare (BC) by determining client eligibility, issuing benefits, tracking program participation and managing support.

Eligibility Determination Process:

1. Applying for assistance:
   - CC: Individuals can either apply in person at a local agency or on-line through ACCESS. (ACCESS is website where individuals can apply for a variety of income support programs in Wisconsin.) All applicants must receive an interview appointment.
   - W-2: Individuals must sign a request for assistance and submit it to the W-2 agency. A series of in-person meetings are required for W-2 applications. W-2 agencies have up to 12 days from the date of the signed request to determine eligibility. The process can be extended to 30 days if extra time is needed to gather verification.
2. Determining eligibility for both CC and W-2:
   - The worker conducts an interactive interview and enters eligibility data into CWW.
   - When the application is completed, the worker prints out the Combined Application Form (CAF) from CARES which details all of the eligibility information. The applicant must sign the CAF to confirm that all the information provided is truthful.
   - To verify eligibility data the worker will:
     - Review Electronic Case File (ECF) for data that has already been verified. ECF is a companion program to CWW that electronically houses scanned verification documents.
     - Process data matches. CARES utilizes data matches to verify eligibility criteria through a third party such as Vital Records to verify date of birth.
     - Require the applicant to provide remaining verification. The worker provides the applicant with a list of outstanding items that must be verified. The applicant has 7 days to provide the verification. All documentation must be scanned into ECF.
   - Once all verification is complete, the worker processes the eligibility determination in CARES.
3. Ongoing eligibility and monitoring:
   - CC: Requires 6-month and 12-month reviews. Interviews may be conducted by phone.
   - W-2: Requires in-person eligibility reviews every 6 months.
   - CC and W-2: Information entered into CWW for one program affects the eligibility for all programs in CWW and prompts an alert that the workers must follow. The worker must review the new information and re-determine eligibility if necessary.
   - CC and W-2: DCF staff monitors W-2 and CC eligibility by reviewing a sample of cases to ensure the appropriate verification has been collected and that data exchanges have been processed timely. CC is also subject to Federal Improper Payments reviews every three years.

WISCONSIN MEDICAID PROVIDER PROGRAM INTEGRITY

The direct responsibility ensuring the integrity of the Program and for the prevention and detection of provider fraud, waste and abuse is housed within the DHCAA/Bureau of Program Integrity (BPI).

BPI Pre & Post Payment Safeguards:

Provider Enrollment and Re-Enrollment

- Over 60 different types of providers and over 60,000
- BPI screens applicants and conducts on-site visits to new high risk benefit providers
- Affordable Care Act that will change enrollment/re-enrollment and put stronger controls in place to prevent fraud, waste, and abuse

Prior Authorization

- Ensures services are medically necessary and provided in a cost effective manner prior to the services being rendered
- Services that require prior authorization include: Home Health, Therapies, Durable Medical Equipment and Outpatient Mental Health
- Wisconsin denies approximately 4% of the services requested, in 2007 this would have been approximately $11M (AF) for just the services noted above

Provider Audit – Fraud, Waste, and Abuse

- Includes program compliance and medical compliance audits
- Expectation to recover ~$14M (AF) annually
- Conducts between 1,500 and 2,000 audits annually
- Audit determination done by:
  - Decision Support tools to identify aberrant billing patterns and areas vulnerable to abuse
  - Complaints
  - Referrals from other government agencies
  - Large payment volume/growth providers
  - Regularly scheduled audits
- Refers suspected fraud to the Medicaid Fraud Control Unit at DOJ and other law enforcement agencies

Relationships;

- US Attorney Health Care Fraud Task Force
- CMS National Fraud & Abuse Technical Advisory Group:
- National Association for Medicaid Program Integrity.
- Medicaid Integrity Institute.
- National Health Care Fraud Summit.
- CMS Fraud and Abuse Focus Group
- National Advisory Committee Medicaid Integrity Education.

Going Forward;

- Implement the Fraud, Waste, and Abuse Provisions of the Affordable Care Act:
  - Tighten controls on providers entering the program and ensuring they are capable of providing services.
  - Continue to coordinate and work with US and WI DOJs, FBI, IRS, OIG on WI-HEAT (The WI Health Care Fraud Enforcement Action Team) which will strengthen existing programs to combat fraud and invest in new resources and technology designed to prevent future fraud, waste, and abuse.
  - Continue work toward performing the 143 audit areas on the 2011 Audit Plan
  - Add audit staff
  - Coordinate audit activities between the Medicaid Integrity Contractors (Fed), Recovery Audit Contractors (State-directed; part of ACA), MetaStar, OIG, and BPI audits.

DHS Public Assistance Fraud Prevention Program Summary

The Fraud Prevention and Investigation Program (FPIP) is based on Chapter 49 of the Wisconsin Statutes. It has been administered in all geographic areas of the state since January 1, 1998. The program consists of fraud prevention, fraud investigation, and fraud overpayment collection activities of the FoodShare, Wisconsin Medicaid, and BadgerCare Plus programs.

As part of the responsibilities for ensuring the integrity of the benefit programs they administer, Income Maintenance (IM) agencies must operate recipient fraud prevention programs to identify and prevent fraud or error from occurring in their programs. The agency determining eligibility for a particular benefit program is responsible for fraud prevention activities in that program. Currently when recipient fraud is determined to have occurred agencies are instructed to take the following actions in this order:

- Correct the case for the next possible payment/benefit month
- Establish a claim for any overpaid benefits
- Request an administrative disqualification hearing (ADH) when there is sufficient documentary evidence that a person or group has committed an intentional program violation (IPV). If an individual is determined to have committed an IPV, they will be ineligible for FoodShare benefits for:
- 12 months with the first offense
- 24 months upon the second offense.
- Permanently upon the third offense.
- Enlist and assist district attorneys to prosecute the most egregious cases of fraud.

When a case worker is alerted to potentially fraudulent activity or the presence of an overpayment, he or she is responsible for identifying the problem and correcting the case. However, the current environment of high caseloads and limited staff resources makes it difficult for many agencies to process overpayment and/or pursue an ADH.

In state fiscal year 2009, the Department of Children and Families (DCF) was created as part of the 2009-11 biennial budget, and the W-2 and Child Care programs moved to DCF. Due to budget constraints and an increased focus on improving the accuracy of the eligibility determinations made prior to issuance of benefits, DHS reduced the GPR available for fraud prevention beginning in SFY 2010 by $500,000. As a result the total fraud prevention funding allocated to counties and tribes for FoodShare, Medicaid, and Child Care activities for CY 2009 was approximately $700,000, a reduction of $1.1 million from the previous year. For CY 2010 agencies were notified that no funding was available from DHS. It is also at this time that DHS and DCF agreed to administer their fraud prevention activities within their own departments.

Current DHS Fraud Prevention and Investigation Program

The primary focus of any model for DHS is fraud prevention through pre-certification investigations. Pre-certification investigations involve the verification of error-prone criteria (i.e., residency, household composition, unreported income, etc.) in a short timeframe before the agency certifies a case for benefits to be paid. The incentive for local agencies to investigate fraud currently is the 15% retention of any money repaid by the offender that the agency can use for other program activities (DHS retains 5% of any amount collected, and the rest is returned to the federal agency). DHS also helps local agencies receive federal matching funds for fraud-related activities under their Income Maintenance contract.

Several data matches are built into CARES and are used during the application process and throughout the life of a case. Data matches provide a strong starting point for eligibility determination and can prevent potential fraud from occurring before the case is certified. These data matches include information

regarding recent employment, Social Security and Unemployment Compensation benefits. Efforts continue to enhance and expand data exchanges to prevent recipient fraud rather than trying to recover it on the back end, including an asset verification system for Wisconsin Medicaid applicants and recipients.

DHS recently received bonus funding from FNS as the result of being one of five states in the country with the most improved participation in the FSP for FFY 2008. DHS has earmarked $325,000 of this bonus funding to enhance local and statewide recipient fraud prevention activities for the FoodShare, Wisconsin Medicaid, and BadgerCare Plus programs. Federal match of this investment brings the total funding available for SFY 2011 to $750,000.

DHS released Administrator's Memo 10-02 on November 5, 2010 to provide locals agencies with information regarding DHS fraud program allocations for CY 2011, and well as program guidance. The program DHS is offering agencies builds on the FPI model piloted from 2007-2009. Agencies were given the option to form or lead a consortium, join a contract that DHS will administer to provide fraud prevention services for the Enrollment Services Center and Milwaukee Enrollment Services (state customer service agencies), or to administer their own program with no DHS funding.

Four consortia have been formed state wide comprising 60 local agencies. Four agencies chose to join the state contract, and fourteen agencies chose to independently operate their program with their own funding. Attachment 1 illustrates the agency FPIP configurations for CY 2011. All agencies (including the independents) must meet the same performance measures for the FPI Program. This allows DHS to compare the consortium model with independent operations to further test and enhance our model using best practices from each of them. The FPIP will enhance and blend with existing fraud prevention processes already in place at DHS:

- Use the federal Public Assistance Reporting Information System (PARIS), which matches Wisconsin data with other states and with federal agencies to identify duplicate benefits and unreported federal employment income.
- The Income Maintenance Quality Assurance (IMQA) process requires agencies to review 1% of their most error prone cases each month for payment and/or processing errors so they can correct the case and provide necessary payment accuracy training to staff.
- Statewide payment accuracy consultation with local agencies to improve payment accuracy.
- Statewide implementation of a targeted 2nd party review system in 2006. Close to 90,000 cases have been reviewed.
- Implementation of the electronic case file system, allowing for standardized and current files.
- System changes to allow for auto-updates of new employment information, child support income, unemployment compensation income and Social Security information.
- Special projects in 2004 such as the Milwaukee case review sweep and a quality control business process improvement project to standardize case review procedures.
- Increased management focus on improving payment accuracy at the local and state level.
- Focus on collective prevention:
    - Front end verification – identify error prone cases before they receive benefits.
    - Income Maintenance Quality Assurance System (IMQA): 1% of cases reviewed by supervisor each month, focusing on the most error prone.
- Streamline policies and processes that support accurate determinations (common policies across programs).

ATTACHMENT 1